Retno: _____
Office Use Only

Medical / Dental Coverage Cancellation

Check all that apply:

Medical Coverage:

- ☐ Retiree
- ☐ Spouse / Domestic Partner
- ☐ Dependant(s)

_____
Please provide name(s) of dependant(s)

Dental Coverage:

- ☐ Retiree
- ☐ Spouse / Domestic Partner
- ☐ Dependant(s)

_____
Please provide name(s) of dependant(s)

I hereby request that the above coverage is cancelled effective ____/_____/_____.

I understand that by canceling medical and/or dental coverage at this time, <u>I will not have the option of re-enrolling</u> in the group plan.

_____
Print Name

_____ _____
Signature **Date**

Seattle City Employees' Retirement System
720 3rd Ave., Suite 1000, Seattle, WA, 98104 Telephone: (206)386-1293, Fax: (206)386-1506